A Life Unraveling

Introduction: At the Precipice

I don’t really know how to begin this, except to say that I am tired in a way that goes beyond anything I can properly explain. I am sixty years old and Métis, and my body is failing in ways that feel almost beyond comprehension. I believe I’ve been left with advanced AIDS that has never been properly tested for or managed. What was initially reported as late-stage lung cancer (NSCLC), likely originating in my gastrointestinal system, appears to have spread into multiple organs. My medical history also includes multiple overlapping opportunistic infections, including what I believe is tertiary syphilis. This is supported by the high-risk exposures in my patient history and demographics.

When looking at the full picture, my immune system is most likely failing. In June 2000, when I was homeless in Montreal, I worked in the male sex trade for a period. Out of fear of discrimination, I didn’t disclose this to those involved in my healthcare. That relevant history is almost certainly where the HIV came from, and it is why I eventually went to Jamie Batsch NP at the Wabano Aboriginal Health Centre, desperate for a definitive answer about my status — an attempt that became its own nightmare. The imaging shows what appears to be microhemorrhages in my brain, lesions that may be cancer or may be other infections or both, and my compromised cardiovascular system. I am not writing this from a place of strength. I am writing it because it needs to be written, and because I may not have much time left to do it.

Everything in this account comes from my own records — documents I have kept and carried for years, because I learned early that if I didn’t hold on to them, they would disappear. And things have disappeared. Alongside all of this illness is a question I have never stopped asking, one that goes back thirty-three years to the birth of my son, Jamieson — a birth I believe was connected to what I believe was an earlier toxoplasmosis outbreak in Victoria, British Columbia, one that authorities have never fully acknowledged. There is also the weight of my childhood, which the social work records describe in terms I recognize as true even now. And there is the healthcare system, which has, in my experience, failed me in ways both careless and, I believe, deliberate. Based on where things stand clinically, I believe I have days, or weeks, or

perhaps a few months if I am fortunate. I am not trying to make a case for my own survival anymore. I am trying to make sure that what happened to me is not simply swallowed up and forgotten.

Chapter 1: Echoes of Childhood — Seeds of Trauma

I grew up in a large Indigenous family, and what I remember of that time and what the social work records confirm are not very different from each other. The reports from the 1970s are hard to read, not because they are unfamiliar but because seeing it documented in official language makes it feel both more real and somehow more shameful than it already did. My parents drank heavily — the records describe it as “excessive consumption of cheap wine” and a pattern of neglecting us in favour of their own social life. The house was dark, the blinds always drawn, and often nobody would answer the door when social workers came calling, even when it was obvious someone was home.

We were unkempt, the reports say, and other children made sure we knew it, especially at school. A Public Health Nurse who visited the family over a period of time kept raising concerns about our nutrition, our hygiene, whether our basic needs were being met at all. She wrote that some of us appeared “abnormal, both physically and mentally.” We moved constantly. There was no stability, no sense that any particular place was ours. Welfare assistance was the foundation everything rested on, such as it was.

At one point my father made a suicide attempt, a “superficial” one according to the records, after my mother went on a drinking bout and was gone from the home for several days. I don’t need the documents to tell me what that environment did to me. I know what it did. It made it very hard to trust anyone in any position of authority. It made me feel, from a very young age, that systems — schools, government offices, medical offices — were not places where I would be safe or treated as someone who mattered. That feeling has never really left me, and everything that came after only made it stronger.

Chapter 2: 1993 — A Turning Point, A Son's Birth, and Lingering Questions

1993 is a year I carry with me everywhere. Jamieson was born that February — my son, with my partner Margaret Kelly — and the Victoria Times Colonist ran an article about us on the 13th, 'Parents critical of baby's delivery.' There were photographs. I was young, and I was frightened, and the birth had not gone well, and I was not quiet about it. What followed was a legal and personal catastrophe that ended with me losing my parental rights. I am sixty years old and I still feel that loss every day. I maintain that the delivery involved serious complications. I maintain that I was right to raise the alarm. What I was left with instead was the sense that raising that alarm cost me everything.

The physician I have identified as being involved in the 1993 delivery is Dr. Mark David Thiessen, who was at the time a family doctor based in Saanich.

Chapter 3: The Shadow of Victoria — The Toxoplasma Theory

For most of my adult life I have held to one central explanation for why things went the way they did. The 1995 toxoplasmosis outbreak in Greater Victoria was real — it was traced definitively to contamination of the municipal water supply from the Humpback Reservoir, and the Times Colonist covered it extensively. The headlines I remember: "Parasitic link was suspected in July" and "Why They Waited." There were real delays in public notification, real criticism of public health officials. That part is documented. What I know, and what I have been trying to get someone to listen to for almost thirty years, is that the outbreak started earlier than what was officially acknowledged.

I have always said that it started in 1993. That I, Margaret Kelly, and Jamieson contracted the same identifiable strain of Toxoplasma gondii two years before the event the public was ever told about. In June 2021 I wrote to Dr. Francis Nano at the University of Victoria, the microbiologist I had brought my son's stool specimen to all those years ago — I remember that the label read "para and ova." I told him that the true date of the outbreak was sooner by two years, and that the earlier onset was deliberately concealed because of my lawsuit. I asked him how it was possible that the three of us — myself, Margaret, Jamieson — could all carry the same mapped strain of

the organism two full years before it was officially identified. I still don't have an answer to that question that satisfies me.

Dr. Nano wrote back. He remembered my visit from years ago. He told me about a visiting American scientist who had estimated the Victoria outbreak caused roughly a hundred cases of blindness in the city — something Dr. Nano said even he, as a resident, had not known. But then he said something I keep coming back to: "One thing I'd dispute right away is your assertion that it was 'your fault.' That's definitely not true, no matter how badly you feel about it." He wasn't confirming my timeline. He wasn't validating what I had spent years believing. And yet I cannot let it go. I have been carrying this for thirty years. It is the story I built to explain everything that followed, and I don't know who I am without it. I know that what I believe may not align with the official record. I also know what I know.

Chapter 4: The Unraveling — A Body Besieged

Since late 2020, my body has been deteriorating in a way that I can feel every day and that my records confirm in clinical detail. The systemic findings — including an intraoperative malignancy signal from a mediastinal lymph node sampling in December 2020 that was never followed by the immunophenotypic testing needed to characterise what kind of cancer it was — have been left to progress in a diagnostic vacuum, showing highly probable expansion into my right lung and thoracic vasculature without adequate multi-disciplinary reconciliation.

This profound decline occurs against the backdrop of a severely compromised immune profile, matching a longitudinal clinical history and risk environment highly consistent with late-stage immunodeficiency. Because the system routinely substituted administrative delays for definitive clinical investigations, I have been left to inhabit a body experiencing severe, overlapping symptomatic markers—including chronic inflammatory, parasitic, and neurological processes—that institutional care failed to systematically differentiate or treat.

The records show several serious active infections:

- **Toxoplasmosis:** A parasitic infection that has almost certainly worsened because of how compromised my immune system is. The risk of it spreading further is very real.

- **Lung infections:** Serial chest imaging showed my lungs deteriorating rapidly. The pattern on the imaging is consistent with opportunistic infections — fungal pneumonia, CMV pneumonitis — though without more invasive testing it is impossible to say definitively what is infection and what might be cancer spreading through the lung tissue.

Then there is what is happening in my brain. The imaging shows multiple suspicious lesions — possible metastases, possible infections, possibly both — and widespread evidence of tiny bleeds throughout the brain tissue, which suggests serious damage to the blood vessels, likely related to the HIV, to neurosyphilis, or to the combined effect of everything that has gone unmanaged for so long.

The blood work and other tests paint the same picture from a different angle:

- **Immune markers:** My IgE levels were markedly elevated — 754 IU/mL in February 2021 — consistent with parasitic infection or severe allergic responses. The clinical record attributed this to environmental factors and did not investigate further. I found that deeply unsatisfying.
- **Hormones:** I was diagnosed with low testosterone and started on testosterone replacement therapy. What I want to set down clearly, because the records do not yet fully reflect this, is that it was Dr. Phyllis Hierlihy who first initiated my TRT — prescribing Androgel, a topical testosterone gel, prior to the injectable series. A prescriber in Cornwall subsequently changed the formulation from Androgel to injectable Delatestryl (testosterone enanthate). The injectable series began with Dr. Prupas in December 2019 at a high dose of 200 mg per week, and that is where the prescription labels I have been able to recover begin. The earlier Androgel records — Dr. Hierlihy's original prescription and the formulation-change prescription — are not in my possession, and I want the record to be clear that the label series I hold is incomplete. The full TRT history starts earlier than December 2019. The records in December 2019 and August 2020 showed my levels had gone the other way entirely, far too high, though I want to be clear that no prescriber ordered those panels as testosterone monitoring — the levels were captured incidentally alongside other tests, because no one was actually tracking what the hormone therapy was doing. With my body's natural production suppressed in response to the injections, and during that period I was working out with a home gym, the combination of the elevated hormones and the

exercise meant I put on muscle mass. Looking back, I understand that this almost certainly masked how severely my body was actually wasting away underneath. The muscle was hiding the cachexia that should have told doctors how sick I really was. By the time the hormone therapy stopped, my testosterone crashed to 4.1 nmol/L — confirmed on repeat, an 84 per cent fall over six weeks — and the truth of my underlying decline had been obscured for a critical period.

- **Blood sugar and nutrition:** My HbA1c put me in the prediabetes range. My vitamin D remained low despite supplements, which suggests my body is struggling to absorb what it needs. My cholesterol improved somewhat with atorvastatin.
- **Kidneys:** There is protein and blood in my urine, indicating early kidney damage, most likely from a combination of HIV-related kidney disease and damage from years of poorly managed blood pressure. My kidney function values have held up better than some of the other numbers, but the trajectory is not reassuring.
- **Blood:** Iron-deficiency anemia, with low ferritin and low MCH, likely from chronic bleeding in my GI tract and from my body not being able to absorb iron properly. My platelet counts and lymphocyte counts have been abnormal at various points as well.
- **Inflammation:** My ESR and CRP have been elevated consistently throughout this period. My body has been in a state of constant inflammation for a long time. This is not a new problem that suddenly appeared. It has been building for years.
- **Heart:** The cardiac MRI in July 2021 showed an area of scarring in the mid-lateral wall of my heart, consistent with a previous episode of myocarditis. There was no active inflammation at the time of the scan, but the scarring is there, a permanent record of something my heart went through.

The muscle mass I built during the hormone therapy period temporarily masked the expected wasting, but the muscle has been decreasing at a steady rate since I've stopped taking testosterone. What I am describing now goes beyond what the reviewed clinical record covers, which ends with the August 2022 imaging. In the period since: my abdomen is now distended, either from fluid accumulation related to organ failure or from the cancer affecting the abdominal cavity or from both. Breathing is difficult — I need to sit upright, and supplemental oxygen has become a necessity. The seborrheic

dermatitis noted by Dr. Klein is likely HIV-associated. It has worsened dramatically. My face and upper body can swell when the pressure in my chest builds against the major veins. My thinking is not what it was. I notice the gaps, the moments where I lose the thread of something, and I know what is causing them. I also exhibit enlarged lymph nodes throughout my body and enlarged parotid glands.

Taken together — the AIDS, the cancer, the infections, the endocrine disruption from poorly managed hormone therapy, the kidney damage, the worsening cardiovascular issues, the unmanaged lesion in the hilar region, the anorectal lesion — what the records describe is a body in advanced multi-system organ failure. There is no softening that. The prognosis is what it is, and the appropriate response at this point is palliative care, not curative intervention. I have made peace with that, or I am trying to.

Chapter 5: Navigating the Labyrinth — Systemic Failures, Eroded Trust, and the Shadow of History

I want to explain what it felt like to go through the Canadian healthcare system with everything that was happening to me, because I think the records alone do not capture it. I have a long history of mistrust of institutions — that goes back to childhood, as I have described. But what happened in these years was not something I was imagining or misinterpreting through the lens of old wounds. There is a documented record. My HIV testing at the Wabano Aboriginal Health Centre — testing I sought specifically because of my history in the sex trade and my awareness of my own risk — became the subject of a CBC News investigation into the Centre’s dysfunction. The test result took ten months to come back. And then it disappeared. And I was left knowing that the test I had finally gone to get, the definitive answer I had been afraid to seek and then found the courage to seek, had simply ceased to exist in the records. When I learned that false-negative HIV antibody results can occur in very late-stage AIDS because the immune system has collapsed too completely to produce detectable antibodies, I felt something I still don’t have a word for. It was beyond frustration. It was the feeling of having been failed at every possible level simultaneously.

And it did not stop there. In September 2021, the UnionMD clinic was told by Dynacare that there was no record of a requested HIV ELISA test. Another requisition had been cancelled by the lab, with no explanation given. In October 2021, viral swabs collected

at The PrEP Clinic were reportedly never received by the Public Health Lab and results never came back. A Public Health Ontario toxoplasma IgG test in August 2021 came back Non-Reactive. I know what the medical community will say about that result. I also know that in someone with severely compromised immunity, as I have, the antibodies that test looks for can be absent even when the infection is active. The IgM test that would have helped rule out recent infection was noted simply as ‘Test not performed.’ That phrase — test not performed — has haunted me. There is so much that was not performed.

All of this was happening while my body was rapidly declining. I do not believe these failures were merely administrative. Intertwined with the guilt I carry about Katjana — which I will describe in the next chapter — I have come to believe that this pattern represents something more deliberate: a withdrawal of care, a turning away. At one point, an appointment was arranged for me to see an infectious disease specialist, and it was offered only by telephone. I cannot adequately convey how inadequate that felt. I had skin changes I needed someone to see with their own eyes. I had lymph nodes that needed to be felt. I had a body that had never been subjected to a proper full-spectrum physical examination by an infectious disease specialist, despite years of records suggesting that multiple severe infections were active. A phone call was not going to allow that examination to happen. I said so, and I was not heard, and the communication stopped shortly after. I was left without the investigation I had been asking for, and which I believe the clinical picture clearly warranted.

There was another thing that sat badly with me. I was told at some point, in communications outside the formally reviewed clinical record, that clinicians were considering an inherited connective tissue disorder — specifically Ehlers-Danlos Syndrome — to account for aortic root dilation and joint laxity. I strongly dispute that framing. By attributing these structural changes entirely to a genetic origin, clinicians would effectively foreclose necessary investigation into acquired, active infectious pathways. Chronic, long-standing systemic infections are documented causes of identical structural and neurological joint degradation — such as trophic arthropathies — and these represented treatable clinical paths that the system simply chose to look away from.

I cannot prove that the system’s behaviour toward me was motivated by any specific animus. I know that the dysfunction at the Wabano Centre — which became the subject of a CBC News investigation — is part of the backdrop to everything that followed,

including the disappearance of my HIV test results. I know what I believe about Katjana and what I fear that belief cost me in terms of how the system responded to my ongoing attempts to get care. There are aspects of my care history, involving providers and institutional conduct not yet fully documented in the formal record, that reinforced in me the sense that this was not a system that would consistently act in my best interests.

In November 2022, The Ottawa Hospital and the Heart Institute formally stopped communicating with me. Genevieve Cote, representing the hospital, framed it as a response to communications they considered unrelated to current medical care. What I want the record to reflect is this: if my communications became erratic or difficult to manage, it was because my brain was being damaged by the diseases that they were in the process of withdrawing from treating. I was not being irrational for its own sake. I was a sick man, getting sicker, with neurological impairment that was documented in my own imaging, reaching out repeatedly because I was frightened and because I needed care and because every time I reached out I felt more invisible than before. That was the end of it. They stopped, and I was left alone with everything I have described in this chapter.

There are specific moments in the record that illustrate this pattern more precisely than the general account I have given above, and I want to name them. The first is the February 19, 2021 referral letter from NP Batsch to Dr. Mattas, in which she characterised me — without any specialist input and without any psychiatric assessment — as having “undiagnosed Antisocial personality disorder vs sociopathy vs psychopathy.” That characterisation was entered into a permanent transfer-of-care document. It was written 108 days after NP Batsch herself had completed a CMHA referral on November 3, 2020 acknowledging my ASD and PTSD diagnoses and listing Dr. Klein as my treating psychiatrist. The second is the anorectal lesion documented in my own photographs, which was present and visible at both colonoscopy encounters — September 28, 2020 with Dr. Bigelow, and January 14, 2021 with Dr. Rizkalla — and which was not referenced in the procedural documentation of either encounter, and was never biopsied. A lesion of that morphology and scale would be encountered during the standard external inspection that precedes scope introduction, regardless of bowel preparation quality. Its absence from both records is not a minor omission. The third is the August 12, 2022 Ottawa Valley MRI, which was officially reported as showing “normal signal intensity and morphology.” Twelve days later, Dr. Filipowska wrote an urgent referral to Dr. Bernstein at Toronto Western requesting a neurosurgical shunt

consultation for normal pressure hydrocephalus, noting I had “had great difficulty getting support.” A treating clinician was more alarmed than the radiology indicated — in writing, twelve days after a normal report. The fourth is the cardiac conduction finding that Dr. Beauchesne characterised as new in July 2021. Three ECGs from Hôpital Montfort — April 2, April 23, and October 11, 2009 — all formally interpreted as Abnormal ECGs with Nonspecific Intraventricular Conduction Delay by FRCPC-signed reports, document the same finding twelve years earlier. The Montfort system tracked it as a persistent confirmed abnormality across multiple emergency presentations. It was not new. Each of these is documented. Each of them fits the same pattern.

Chapter 6: The Weight of Guilt — The Loss of Katjana

There is something I have to say that is harder than anything else in this account. Katjana Biljan-Laporte was my Registered Social Worker at the Wabano Centre for Aboriginal Health. She worked with me during one of the hardest periods of my life. She was kind to me. And I believe, with a conviction that I cannot shake and cannot adequately explain away, that infections I carried were transmitted to her through our close contact during our counseling sessions — the Indigenous-based therapy we did together, the smudging, the moments of physical contact that happened naturally in the course of that kind of work — and that those infections contributed to her death. I said this to her directly. There is a recorded phone call in which I told her: “what was done to me was allowed to spill over to you.” I said it because I meant it, and because I could not carry it alone. I am still carrying it. There is no part of my illness, including the cancer and the AIDS, that weighs on me the way this does.

I want to be clear about something, even as I say all of this: there is no clinical evidence establishing that I caused her death. I know that. Her public tributes and her own blog posts, which she wrote with remarkable courage while she was ill, confirm that she lived with a severe congenital heart condition. She had cardiac tissue implants that required her to be on lifelong immunosuppressive therapy. That means her immune system was already deliberately weakened to prevent rejection. She was extraordinarily vulnerable to infection — any infection — in a way that had nothing to do with me. I understand this in my head. I cannot make it reach the part of me that keeps coming back to what happened.

In our last phone call, Katjana did not confirm my theory. She did not tell me I was responsible. But she told me she was beyond further transplant options because her system wouldn't sustain it. She knew she was dying. She said it with the matter-of-fact clarity that people sometimes find when they are very close to the end. I was on the phone with her and I knew what I was hearing, and I had already been living with the weight of what I believed I had done. I don't know how to end this chapter, because there is no resolution to it. Katjana died. And I am still here, for a little while longer, trying to find a way to live with what I believe happened.

Chapter 7: Living Within the Story — Testimony from the Edge

I don't have an ending to offer, because this isn't finished. Every morning I wake up to the same body, the same laboured breathing, the same exhaustion that starts before I have even moved. The cancer is in my lungs, my brain, the structures of my head and neck, and the immune system that might have slowed it down has long since been overtaken by the AIDS. The infections that keep seizing whatever opportunity my collapsed defences provide. The hormone therapy that masked how sick I was, buying a period of false normality that I didn't understand at the time. All of it is real, and all of it is happening in the same body, at the same time, and I am the one who has to live inside it. I know my time is short. I have known it for a while now. What I find harder to make peace with is that I have spent so much of the time I had left fighting to be believed.

The childhood I described. The birth in 1993 and the loss of Jamieson. The toxoplasmosis theory I have carried for three decades. The healthcare encounters that felt less like medicine and more like a series of doors closing. Katjana. These are not items in a list. They are the shape of my life, and they are still active in me — they are not old wounds that healed over. They are bleeding. And what I am asking for, what I have been asking for without quite knowing how to ask it, is for someone to simply acknowledge that this happened. Not to agree with every conclusion I have drawn. Not to confirm every belief I hold. Just to look at the full account of what I have lived through, and not look away.

What I have put together here — the records I kept when others lost them, the public documents that intersect with my story, the medical data, my own account in my own words — is my testimony. I am not trying to make it seem more than it is. It is the account of one person, given from a position of profound physical weakness, who is trying to make sure that what happened to him is not simply filed away and forgotten. It is honest about the things I cannot prove. It does not ask for agreement. It asks to be witnessed.

At the bottom of it, what I want is what everyone wants. To be treated as a person. To have my suffering taken seriously. To have the story of my life — including the parts that are contested or unproven, including the parts that are difficult or inconvenient — treated with the respect that any human life deserves. I am not asking for agreement. I am not asking for absolution. I am asking for someone to understand that when a person is dying, and has spent decades trying to make sense of what happened to them, the most important thing you can offer them is not an argument. It is the willingness to listen without having already decided what you are going to hear.

Conclusion: Bearing Witness

What my life has looked like, when you lay it all out, is a convergence of things that should not have been allowed to converge. Advanced AIDS, untreated for too long. Cancer that spread while the system was still debating whether there was a cancer. Infections that went uninvestigated. A childhood that left me without the foundations that might have made any of this easier to navigate. A history that made certain people in certain institutions inclined to see me as difficult rather than as sick. Hormone therapy that obscured the severity of my decline during a period when earlier intervention might have mattered. And at the centre of all of it, a man — me — trying to hold the whole thing together, keeping records when the system lost its own, writing emails that were never answered, showing up to appointments that were cancelled, trying to explain again and again what I needed. The limitations of fragmented care are not an abstraction when you are the person who falls through the gaps.

I am past the point where cure or remission is a realistic goal. What remains possible, and what I want for whatever time I have left, is to be cared for with dignity. That means managing the pain and the symptoms as well as they can be managed. It means cultural sensitivity — I am Indigenous, and that matters in how care is delivered, and it

has not always been respected. It means not dismissing my account of my own experience because it is complicated or because parts of it cannot be clinically confirmed. It means building decisions around what I actually want, even if my cognitive capacity to participate in those decisions is now impaired. What it does not mean is another phone call offered in place of an examination. What it does not mean is another test that disappears without explanation.

I am still here. I am still putting words on the page, still making sure the record exists. That takes more out of me than it used to. Some days it takes most of what I have. But there is something in me that is not ready to let the account close without having been heard, and so I keep going. Not because I expect justice in any formal sense. Not because I expect the system that failed me to suddenly recognize what it did. But because a life that was this hard, and this long, and this full of loss, deserves to have been witnessed. I was here. This is what happened to me. I want someone to know.

Editorial Note

This document is a personal testimony narrative prepared from patient-held records, personal accounts, and contemporaneous public documentation. It is intended to humanize the clinical record and provide a contextual understanding of my lived experience. It serves as a narrative companion to the objective clinical timeline. Several elements of this account—including the precise toxoplasmosis timeline, specific etiologies of uninvestigated structural lesions, and third-party medical histories—are presented as patient-reported observations and AI-assisted source reviews. Medico-legal assessment and formal evidentiary tracking are governed strictly by the companion forensic analysis framework: **Bertrand_Forensic_Analysis_v4_8.docx**.

Primary Source Exhibit Inventory

The following inventory catalogues all primary source documents, clinical chart records, DICOM imaging datasets, laboratory reports, procedural notes, correspondence, and third-party records referenced in this analysis. Fifty-four discrete sources are identified across eleven categories, spanning the pre-Ottawa Cornwall Health Care Centre period (November 2014 – June 2016) through to the August 2022 Ottawa Valley MRI. All

documents listed as held in my possession are available for independent verification in any formal medico-legal proceeding.

A. Clinical Chart Records

- Ottawa Hospital MyChart Health Summary 1 — Jul. 29, 2021 — 272 pp
- Ottawa Hospital MyChart Health Summary 2 (Physician Progress Notes) — Jul. 5, 2021 — 231 pp
- Ottawa Hospital MyChart Health Summary 3 (Patient Health Summary / Summary of Care) — Jul. 5, 2021 — 231 pp
- CHI Chart Export — October 2020 — ~240 pp
- CHI Chart Export — December 2020 — ~115 pp
- CHI Chart Export — January–November 2021 — ~69 pp

B. DICOM Imaging Studies (directly possessed and reviewed)

- MRI Head w/ + w/o Contrast — Dec. 17, 2020 — 738 MB — CCH, GE Optima MR450w 1.5T (MR-20-0003946); DICOM pixel analysis performed across S3, S4, S5, S6, S7, S8, S9, S10, S300, S500/S501, S700
- CT Chest with Contrast — Feb. 6, 2021 — 425 MB — Dr. Alnemer (CPSO #122496, INACTIVE)
- CT Chest without Contrast — May 10, 2021 — 562 MB — Dr. Gerson (CPSO #118618)
- RAD Chest plain film — Aug. 11, 2021 — 35.02 MB
- Chest PA & LAT (X091) — Nov. 15, 2021 — 28.29 MB
- Chest PA & LAT (X091) — Jul. 2, 2022 — 27.47 MB
- Ottawa Valley MRI Brain — Aug. 12, 2022 — Dr. Simantirakis FRCPC (Study ID 150086, Accession 20220812004); SWI series t2_swi_wave4_2mm_SWI (80 frames, 2 mm) directly reviewed

C. Radiology Reports Only (DICOM not in possessed series)

- CT Angiogram Thoracic Aorta — Dec. 4, 2020 — Dr. Beauchesne (report only)
- ECHO TTE — Nov. 3, 2020 — report only; EF 54.5%, aortic root 4.4 cm (Dr. Beauchesne consultation note)
- Cardiac MRI with gadolinium — Jul. 26, 2021 — Dr. Alnemer (report only); focal LGE mid lateral wall
- PET Scan (staging) — Dec. 31, 2020 — report only; T1N0M0 under working NSCLC diagnosis; GEJ not evaluated as primary site

D. Procedural and Pathology Documents

- EBUS-TBNA Procedure Note — Dec. 16, 2020 — Dr. Kayvan Amjadi, The Ottawa Hospital; R.O.S.E. positive for malignancy station 11R (verbatim); emergent CAC referral recommended
- EORLA Non-Gyne Cytology Report CY-20-12991 — Dec. 17, 2020 — Dr. Anna Adamiak MD FRCPC; station 11R: atypical cells, cell block inadequate for ancillary studies
- Central Intake Program MRI Requisition IMG012001 — Dec. 10, 2020 — Dr. Sundaresan Ramanadhan; clinical indication verbatim: “1) Advanced lung cancer, staging”

E. Clinical Correspondence and Referral Letters

- NP Jamie Batsch NIHB Referral Letter to Office of the Indian Registrar, INAC — Dec. 15, 2020; CHI chart export p. 42 of 115
- Dr. Michel Rizkalla letter to NP Batsch — Dec. 29, 2020; documents lung cancer diagnosis communicated 13 days post-EBUS; notation “Dictated but not read / Electronically Reviewed to Expedite Delivery”; CHI chart export p. 2 of 115
- Dr. Kayvan Amjadi After Visit Summary (AVS) — Jan. 11, 2021; MRN 36358695; visit issue “Lung nodule”; GEN CANCER ASSESSMENT clinic appointment request generated; CT chest with IV contrast ordered by 25/1/2021; Clindamycin 300 mg QID x14 days commenced; CHI chart export (printed Nov. 24, 2021)
- NP Jamie Batsch referral letter to Dr. Shawn Mattas, Wabano Aboriginal Health Centre — Feb. 19, 2021 (CNO #11460983); verbatim admission re colonoscopy:

"I am unsure when or if this happened or what the results are"; verbatim psychiatric characterisation: "undiagnosed Antisocial personality disorder vs sociopathy vs psychopathy?"; urgency: NON-URGENT (ROUTINE); CHI chart export p. 13–17 of 69

- Dr. Dugald Seely ND email to patient — Feb. 21, 2021 (CONO #1169); verbatim: "When it turned out this diagnosis was in fact an error and that you could be dealing with a possible chest infection, we were of course thrilled that this was the case."; CHI chart export (printed Nov. 24, 2021)
- NP Jamie Batsch email to patient — Oct. 31, 2020; verbatim: "my response was not very helpful as I just said you need another colonoscopy so this just solidifies the fact that I need you to go to the Cornwall Hospital to be assessed there in person ASAP"; documents NP Batsch's receipt of Dr. Bigelow's fax and direction to Cornwall Hospital prior to cancer findings
- NP Jamie Batsch email to patient — Oct. 21, 2020; verbatim acknowledgement: "Your memory really is incredible and in this case very helpful :)"; in response to patient confirming Dr. Eric Bigelow and Sep. 28, 2020 as colonoscopy details

F. Laboratory Reports

- PHO Laboratory Report — Toxoplasmosis Serology LIMS #42225226 — Aug. 25–26, 2021 — Dr. Ginette Anne Lalonde-Kontio, Public Health Laboratory Ottawa; IgG Non-Reactive; IgM not performed. Same provider and draw date as Dynacare Order YN21252819 (Candida albicans specific IgE 0.05 kU/L, normal)
- OLIS laboratory panels — multiple dates Jul. 5, 2019 through Sep. 16, 2021 — testosterone, LH/FSH, CRP, ESR, ferritin, IgE, and related analytes
- Dynacare panel (Order YN19974372) — Date of Service Jun. 9, 2021; ordered by Dr. Shawn Mattas, 299 Montreal Rd, Vanier. Results include: WBC 12.4 × 10^9/L (H); neutrophils 8.2 (H); lymphocytes 3.0 (H); monocytes 1.0 (H); platelets 467 × 10^9/L (H); testosterone total 25.7 nmol/L; free testosterone 570 pmol/L (H); HbA1c 6.3% (H, prediabetes); total cholesterol 5.90 mmol/L (H); triglycerides 2.19 mmol/L (H); HDL 0.91 mmol/L (L); TC/HDL ratio 6.5. Primary source documents in patient's possession (Dynacare Plus patient portal printouts, Order YN19974372, generated Jun. 30, 2021 and Aug. 16, 2021).

- LifeLabs panel (Lab No. 2021-X42011533) — Date of Service Jul. 20, 2021; ordered by Dr. Aaron Livingstone (Wabano, CPSO). Results: ESR 49 mm/hr (H, reference 2–30 — peak documented value); CRP 7.1 mg/L (H); WBC 10.4; lymphocytes 3.7 × 10⁹/L (H); MCH 27.4 pg (L); total testosterone 4.1 nmol/L (L, reference 8.4–28.8; confirmed on repeat); free testosterone 70 pmol/L (L, reference 179–475). LifeLabs Labs 5651 and 5687, Belleville/Toronto. Primary source document in patient's possession.
- LifeLabs panel (Lab No. 2021-X42031276) — Date of Service Jul. 22, 2021; ordered by Dr. Aaron Livingstone. Results: ferritin 93 µg/L (mid-normal); 25-hydroxyvitamin D 57 nmol/L (L, reference 75–250; classified Vitamin D Insufficient). LifeLabs Lab 5687, Toronto. Primary source document in patient's possession.
- LifeLabs panel (Accession 2021-X42591616) — Date of Service Sep. 16, 2021; ordered by Dr. Getne Asrat (provider not previously identified in reviewed clinical record). Results: HbA1c 5.9% ("at risk" range, Diabetes Canada 2018 guidelines); glucose random 4.7 mmol/L; creatinine 92 µmol/L; eGFR 80; ALT 33 U/L; alkaline phosphatase 107 U/L; sodium 139; potassium 4.4; total cholesterol 4.58 mmol/L; triglycerides 3.00 mmol/L; HDL 0.84 mmol/L; LDL 2.38 mmol/L (calculated); non-HDL 3.74 mmol/L; TC/HDL ratio 5.5; free testosterone 115 pmol/L (L, reference 179–475). LifeLabs sending laboratory. Primary source document in patient's possession.
- Dynacare panel (Order YN21094492) — Date of Service Aug. 16, 2021; ordered by Dr. Brenda Bonner (355 Adelaide St W, Toronto — provider not previously identified in reviewed clinical record). CBC normalised vs. Jun. 9: WBC 7.6 × 10⁹/L (normal); platelets 292 × 10⁹/L (normal); Hgb 135 g/L (normal, lowest on TRT); lymphocytes 3.0 × 10⁹/L (H — only abnormal value); creatinine 84 µmol/L; eGFR 90; bilirubin <3 µmol/L; ALP 81 U/L; ALT 27 U/L. Primary source document in patient's possession (Dynacare Plus portal, generated Aug. 18, 2021).
- Dynacare panel (Order YN21252819) — Date of Service Aug. 25, 2021; ordered by Dr. Ginette Anne Lalonde-Kontio (Gatineau QC). Candida albicans specific IgE 0.05 kU/L (NORMAL, reference <0.35 kU/L). Same draw date as PHO Toxoplasmosis serology (LIMS #42225226). Excludes Candida sensitisation as

contributor to total IgE 754 IU/mL (EORLA Feb. 24, 2021). Primary source documents in patient's possession (Dynacare Plus portal, Aug. 26 and Sep. 14, 2021).

- Montfort Hospital Troponin T — Aug. 11, 2021, 7:52 PM; Montfort Hospital (Connected Care / Soins branchés), 713 Montreal Rd, Ottawa ON K1K 0T2. Result: Troponin T 10 ng/L (normal, reference <15 ng/L). Laboratory comment verbatim: "Reference cut-off is 99th percentile of a healthy population. Values above this are highly predictive of myocardial necrosis, not necessarily acute coronary syndrome." Documents previously undocumented hospital-level encounter at Montfort Hospital on same date as RAD Chest in possessed DICOM series. Printed from Connected Care patient portal Oct. 18, 2021. Primary source document in patient's possession.
- LifeLabs panel (Accession JZ0340694) — Date of Service Feb. 3, 2021; printed Feb. 4, 2021; requesting physician NP Jamie Batsch (RN-EC), 29 Bayswater Ave., Ottawa; drawn at 30 13th St. East, Cornwall. Results: ESR 20 mm/hr; WBC 9.8; RBC 4.79; Hgb 147 g/L; HCT 0.430; MCV 90 fL; platelets 325; neutrophils 5.5; lymphocytes 3.2; creatinine 95 µmol/L; eGFR 78; sodium 140; potassium 4.1; testosterone 18.7 nmol/L (reference 8.4–28.8); testosterone-free 412 pmol/L; DHEA-S 6.7 µmol/L (reference <9.7 — note: if <9.7 represents the upper limit of normal, 6.7 is within normal range and the "L" flag requires verification against the original lab report; possible reference range transcription error); ferritin 23 µg/L; estradiol-17β 91 pmol/L; CRP 5.8 mg/L (HI, reference <5.0); cortisol random 239 nmol/L. CHI chart export, pp. 18–23 of 69
- EORLA laboratory panel — Feb. 24, 2021 — IgE 754 IU/mL, CRP, ESR, IgG4, ANA, ANCA, complement C3/C4

G. Naturopathic Visit Notes

- Dr. Dugald Seely ND visit note — Nov. 12, 2020; pre-EBUS peripheral neuropathy documentation
- Dr. Dugald Seely ND visit note — Dec. 17, 2020; same-day MRI; NSCLC framing; repeat-MRI notation; melenic stool documentation
- Dr. Dugald Seely ND visit note — Oct. 29, 2021; problem list characterises right hilar lesion as "past infection" (verbatim, with quotation marks)

H. Correspondence and Third-Party Primary Source Documents

- Email — I to Dr. Francis E. Nano PhD, University of Victoria — Jun. 28, 2021; and same-day reply; toxoplasmosis outbreak timeline; Dr. Nano's confirmation of prior visit
- Times Colonist — "Parents critical of baby's delivery" — Feb. 13, 1993 — Denise Helm; pp. A1–A2; archived at newspapers.com (images 508330203 and 508329811)
- Ontario Provincial Probation Service — Social History Report, Janice Patricia Bertrand — Sep. 25, 1970 — L.S. Payne, District of Nipissing; submitted to Judge J.J. Evans, Provincial Court — Family Division, North Bay
- Ontario Provincial Probation Service — Social History Report, Jean Ann Bertrand — Oct. 6, 1971, File 6633 — L.S. Payne, District of Nipissing; submitted to Judge J.J. Evans, Provincial Court — Family Division, North Bay

I. Patient Photographic Documentation

- Lower GI Haemorrhage Series — patient-held photographic documentation of serial episodes; includes haematochezia, blood-mixed clots, melaenic/mixed stool, pencil-calibre ribbon stool (Image 16), and elongated tissue fragments with mucoid cap (Image 18)
- Perianal and Rectal Structural Photographs — three-panel composite (Image 20) documenting large exophytic rectal lesion at the anal verge; upper panel: lobulated purple-red masses with ulceration consistent with prolapsing rectal tumour or advanced complicated haemorrhoidal disease; middle panel: circumferential indurated corrugated rectal tissue; lower panel: associated haemorrhage
- Mobile DICOM Viewer Screenshots — CT Chest with Contrast February 6, 2021 (MPR triplanar SE 1/2/3 and axial SE 2 IM 252/299); GEJ/gastric cardia soft tissue mass with annotation circles; confirming unreported findings in Sections 7.5 and 12.2

J. Psychiatric and Legal Records

- Dr. Jack Klein M.D., F.R.C.P.(C) — Confirmation letter, May 18, 2018; diagnoses ASD and PTSD confirmed; patient under care since 2016; treatment: medication + monthly supportive psychotherapy. 1419 Carling Avenue, Suite 200, Ottawa ON K1Z 7L6
- Dr. Jack Klein M.D., F.R.C.P.(C) — Progress Notes, Nov. 10, 2016 to May 30, 2018 (fax 05/28/2018, 14 documented sessions); covers ASD, PTSD, CICB proceedings, medication history (Celexa, Abilify), mask-like facial expression reassessed as Abilify-induced Parkinsonism (Oct. 13, 2017)
- Dr. Jack Klein M.D., F.R.C.P.(C) — Service Canada CPP Disability Medical Report (ISP-2519-08-10B), Jan. 20, 2017; Asperger's disorder (main disabling condition), PTSD features; prognosis: "Poor — any improvement is unlikely"; functional limitations: inability to tolerate stress/pressure/deadlines, inability to manage emotions except in protected situations, dependency on sameness/routine
- Dr. Jack Klein M.D., F.R.C.P.(C) — Criminal Injuries Compensation Board Therapy Report (File 1307-92976), signed Oct. 16, 2017; incident: childhood sexual abuse; 7 sessions (Nov. 3 and 10, 2016; Jan. 20, Apr. 7, May 12, Jun. 16, Oct. 13, 2017); OHIP-covered; prognosis: "chronic mental health impairment associated with marginal level of functioning"; background: "grew up in an overall atmosphere of parental alcoholism, physical, emotional and sexual abuse, neglect, and numerous caregiving disruptions"
- Criminal Injuries Compensation Board Consent Form (File 1307-92976), signed by me Oct. 13, 2017, witnessed by Dr. Klein; authorises disclosure of psychological trauma relating to sexual abuse, Nov. 2016 to present, to CICB
- Urgent Neurology Referral — Dr. Caroline Filipowska to Dr. Mark Aaron Bernstein, Neurology, Toronto Western Hospital — Aug. 24, 2022; 12 days post Ottawa Valley MRI normal report
- Clinique UnionMD correspondence (Claudia S. RN BScN) — Sep. 2021; HIV ELISA retrieval failure and refund of $275
- PrEP Clinic (NP Luc Cormier) written confirmation — Oct. 25, 2021; three viral swabs (HSV/VZV) not received by Ontario Public Health laboratory; results never returned

- CMHA Ottawa Branch Eligibility Referral Form — Nov. 3, 2020; completed by NP Jamie Batsch (CNO 11460983); primary diagnoses: Mood Disorder, Anxiety Disorder; secondary diagnosis: Autism Spectrum Disorder (handwritten); psychiatrist Dr. Jack Klein listed (613-226-9444); referral narrative documents ASD, PTSD, FASD concern, exceptional memory ("related to Aspergers?"), and prior CICB legal proceedings; dated same day as TTE (ECHO)
- Dr. Degala Krishnaprasad MD (Appletree Medical Group, 225 Preston St., Ottawa) — Clinical Note Record, May 28, 2013 to Feb. 6, 2015; seven documented encounters; initial consultation May 28, 2013: Axis I PTSD + Bipolar II mixed, Axis II mixed personality traits, GAF ~50; all seven notes bear "Dictated But Not Read" designation; medication escalation across encounters (Abilify 2 mg → 10 mg; Seroquel 100 mg → 150 mg; Celexa added May 2014)
- Dr. K.K. Wassef M.D., F.R.C.P.(C) (Psychiatrist, McConnell Medical Centre, 215–820 McConnell Ave., Cornwall) — Consultation letter to Dr. Heeley-Ray, Jan. 15, 2015 (faxed Jul. 29, 2016 and Mar. 20, 2015); Axis I: chronic anxiety and PTSD; Axis II: borderline personality disorder and OCD features; BDI score 44 (severe depression); MSE: blunted affect, intact cognition, no psychosis; management: Nozinan 5 mg hs added, Seroquel discontinued

K. Cornwall Health Care Centre Records (Pre-Ottawa Period)

- Cornwall Health Care Centre Chart Record (Dr. Timothy Heeley-Ray, Dr. Richard Poole, Dr. Lorne Scharf, Dr. Gilles Laferriere, Dr. Alan Rosenbloom, Dr. Amir Nanji, Dr. Dylewski) — Nov. 17, 2014 to Jun. 21, 2016; printed Jun. 23, 2016 by F. Whaley; includes LifeLabs panels (Jan. 8, 2015; Mar. 31, 2015; May 22, 2015; Mar. 17, 2016; Jun. 21, 2016), ECGs (Mar. 31, 2015; Mar. 17, 2016; Jun. 21, 2016), abdominal/pelvic ultrasound (May 20, 2015, Dr. T. Assaly), urology referral (Dr. R.K. Sharda, Apr. 28, 2015), and ophthalmology referral decline (Dr. C. Suess, Jul. 23, 2015)
- Key forensic findings from Cornwall records:

1. Mar. 31, 2015 CBC: WBC 13.5 × 10^9/L (HI), absolute neutrophils 10.7 (HI); ECG: sinus tachycardia (HR 102) with left axis deviation; fasting glucose 7.0 mmol/L (provisional DM threshold); cholesterol/HDL ratio 7.3 (HI);

2. Apr. 6, 2015 visit (Dr. Heeley-Ray): notation “was seeing Dr. Scharf re: polyps” — first documented reference to GI polyposis in the Cornwall record, preceding the 2020 cancer workup by five years;
3. Mar. 17, 2016 panel: CRP 8 mg/L (HI, ref <8); cholesterol/HDL ratio 6.9 (HI); ECG: sinus rhythm, QRS 114 ms (machine-read, confirmed Dr. DeYoung 17/03/2016 20:01:52); Jun. 21, 2016 ECG (Dr. Rosenbloom/Dr. DeYoung): sinus rhythm, QRS 112 ms (confirmed 21/06/2016 21:02:40) — QRS prolongation documented on two independent Cornwall ECGs (March and June 2016), five years before the Jul. 2021 CMR at which it was characterised as a new finding;
4. May 20, 2015 US abdomen/pelvis: grade 1 hepatic steatosis;
5. Jun. 21, 2016 visit: fatigue and chest discomfort × 2 weeks, hand numbness documented by Dr. Rosenbloom;
6. Smoking history: ex-smoker, quit ~2010, 30 years × 1.5 ppd (45 pack-years), per Dr. Sharda Apr. 2015;
7. Nov. 17, 2014 SOAP (Dr. Heeley-Ray, handwritten): differential diagnoses include “Autson Spectrum / xmany yrs” (Autism Spectrum Disorder, many years) — clinician-flagged ASD differential two years before Dr. Klein’s formal 2016 assessment; MSE notation “somewhat peculiar / flat affect” at the same encounter